STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN47170

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F0000	This visit was for Investigation of Complaint IN00090827. Complaint IN00090827 - Substantiated. Federal/state deficiencies related to the allegations are cited at F272 and F328. Survey date: 5/20/11 Facility number: 000421 Provider number: 155417 AIM number: 100288340 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 35 Total: 35 Census payor type: Medicare: 3 Medicaid: 25 Other: 7 Total: 35	F0000	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Scottsburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 19, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/24/11 by Suzanne Williams, RN			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure the resident was assessed	F0272	**F 272** **It is the policy of this facility to conduct initially and periodically a**	05/27/2011

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	related to the intravenous insertion site and the amount of fluids infused for 1 of 2 residents reviewed related to intravenous infusion in a sample of 3. (Resident M) Findings include: The clinical record for Resident M was reviewed on 5/20/11 at 11:50 a.m. Nurse's Notes for 5/14/11 at 7:30 p.m. indicated, "[Name of Nurse Practitioner] came to facility to check res. [resident]. N.O. [new order] morphine sulfate 0.5 - 1.0 mg IV 1 - 2 [symbol for hours] PRN [as needed]. IV site to L [left] FA [forearm]. Flushes with ease, blood return." Nurse's Notes on 5/15/11 at 12:00 a.m., indicated morphine sulfate was administered as ordered, and the IV site was assessed with "... [symbol for no] S/S [signs and symptoms] of infiltration or		**comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity, including assessments related to intravenous insertion sites and the amount of fluids infused.** **1.)** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** **The survey was conducted on May 20, 2011; however, the IV was discontinued on May 18, 2011 and the site has not been used for IV fluids since that time. Nurses Notes for this resident indicate on 5-20-11 that there were no signs of infiltration at that time. This resident has not had any other IV therapy since that time.** **An in-service was held on 5-20-11 for RNs and LPNs on the facility policy and procedure regarding IV therapy and assessments that should occur when IV**	

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	infection noted...." Nurse's Notes indicated the IV site was assessed again, about 12 hours later, on 5/15/11 at 12:30 p.m. with "...Site clean and dry [symbol for no] S/S infection or infiltration...." Nurse's Notes indicated the IV site was assessed again, about 24 hours later, on 5/16/11 at 12:53 p.m. as "...[symbol for no] S/S infection or infiltration to IV site." Nurse's Notes for 5/16/11 at 10:00 p.m., indicated, "[Name of attending physician] here to visit & N.O. noted...D5 1/2 [5% dextrose solution with 1/2 strength normal saline] [symbol for with] 20 mEq [milliequivalents] of KCl [potassium chloride] at 100 cc hr [hourly] cont [continuous]...." Nurse's Notes for 5/16/11 at 2:00 a.m., indicated, "IV fluids started and infusing at 100 cc/hr via LFA #22 [gauge of IV cannula]...."		**therapy is being administered, IV documentation and the form to be used for documentation of IV therapy.** ***2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.*** **No other residents were affected.** **There were no other residents receiving IV therapy in the facility at the time of survey.** **In the future, if the DON should find that intravenous therapy is not being administered, assessed, or documented as per facility policy, she will intervene immediately to make sure that the resident is being cared for and that appropriate documentation is in place to support the administration of the IV therapy. Once that is done, she will re-train any RN or**	

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	Nurse's Notes for 5/17/11 at 7:40 a.m. indicated the IV fluids continued to infuse at 100 cc per hour. The next Nurse's Note related to the IV site was 5/17/11 at 12:00 p.m. and indicated, "Res. IV site infiltrated. Noticeable pooling to L FA & hand...." Physician's orders were received to discontinue and relocate the IV. Documentation failed to indicate further assessment of the IV site where the IV cannula was removed or the area affected by the infiltration to the left arm. Nurse's Notes for 5/17/11 at 2:00 p.m., indicated, "IV inserted into R [right] AC [antecubital] X 2 attempts 22 g. IVF [intravenous fluids] cont. as ordered...." The next Nurse's Note related to the IV site was 5/18/11 at 3:45 a.m. and indicated, "N.O. D/C [discontinue] IV R AC r/t [related to] infiltration.		**LPN who has been involved in the identified noncompliance regarding the facility policy and procedures for IV therapy. Progressive disciplinary action will be followed for continued noncompliance.** ***3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** **The IV documentation form includes places to document every 8 hour site monitoring for signs and symptoms of complications, IV fluid order, the rate of infusion, and the amount of fluids infused each shift. The nurses have been instructed that they are to document in the nurses' progress notes any unusual observations or complications that they observe or assess whenever IV therapy is being administered.** **The "Medication Pass Intake" form was revised to**	

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	Hold IVF until morning...." Documentation in Nurse's Notes failed to indicate the IV site was assessed from time of insertion into the right arm until more than 12 hours later. Documentation in the Nurse's Notes failed to indicate an amount of IV fluids administered to the resident. The Treatment Record for May 2011 indicated, "D5 1/2 NS [symbol for with] 20 mEq of KCL cont" with an initial for a nurse's signature on the 10:00 p.m. to 6:00 a.m. shift for 5/16 to 5/17/11. No other documentation was indicated on the Treatment Record related to the continuous infusion. The documentation failed to indicate the amount of IV fluids infused. The Resident Fluid and Meal Percentage Intake Log failed to indicate the amount of fluid received intravenously.		**reflect the amount of fluids received via IV each shift. This amount will be transcribed from the MAR each day onto the residents individual Intake Log.** **The Director of Nursing or designee will audit the 24-hr. report and the focus charting at least 5 days per week. If she finds that a resident has new IV orders, she will ensure the IV orders include IV fluid order, the rate of infusion, and the amount of fluids infused per shift and monitoring for signs and symptoms of complications. She will review the documentation on the forms and care plan to make sure that it is complete and that the appropriate assessments & the results of those assessments have been noted as required. If any issues are identified during the reviews, the Director of Nursing will follow through as indicated in question #2.** ***4.) How the corrective***	

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	The resident's care plan, dated 5/14/11, indicated, "Problem: IV site to (L) [left] hand" with undated notation of "Infiltrated - move to L [sic] antecubital." Interventions included, but were not limited to, "Monitor IV site for changes: i.e. redness, drainage, pain, swelling....Monitor intake and output....Document IV administration on flow sheet/MAR [Medication Administration Record]." The facility's "IV Policy and Procedures" was provided by the MDS (Minimum Data Set) Coordinator on 5/20/11 at 1:30 p.m. Review of the procedure for "Monitoring an IV Site" indicated, "IV sites will be monitored at least once every 8 hrs [hours] by the IV trained nurse....Step 1. Observe the IV site for signs of complications described in the following: Edema - Swelling is an indication of infiltration; Blanching - Blanching is an indication of infiltration; Redness - Redness in the area of the		***action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** **The Director of Nursing or designee will bring the results of the audits (QA audit tool # 272-1) to the monthly QA & A Committee meeting.** **The committee will review the results and provide recommendations for any process identified as needing improvement. This will be followed up by the Director of Nursing or designee, who will report on the status of these recommendations at the next QA & A Committee meeting.** **While the process of the review of the 24-hr. report and the focus charting by the Director of Nursing or designee, will continue on an ongoing basis, the documented audits will continue through the next 90 days. At that time, the QA &**	

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	tip of the catheter and along the vessel may be an indication of phlebitis and/or infiltration; Moisture or exudates at insertion site: This may indicate...Infiltration...Infection of the area." Review of the procedure for "Continuous IV Administration of Fluids/Medications" indicated, "Monitor ...the site throughout the infusion...." During interview at this time, the MDS Coordinator indicated the facility did not use a separate IV Flow Sheet to record administration of fluids but the information would be on the MAR and Intake and Output Record. She indicated the information was not indicated on the resident's records. This federal tag relates to Complaint IN00090827. 3.1-31(a)		**A Committee may terminate the documented audits if the facility has reached 100% compliance.** **Date of Compliance 5-27-11.**	

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure management of care for an intravenous (IV) infusion related to assessment of the venous access site and amounts of fluids administered for 1 of 2 residents reviewed related to intravenous infusion care in a sample of 3 residents. (Resident M) Findings include: During observation on the Initial Tour on 5/20/11 between 10:30 a.m. and 11:25 a.m., with the MDS (Minimum Data Set) coordinator, Resident M was observed in bed lying on the right side wearing a hospital gown. The resident's left	F0328	**F 328** **It is the policy of this facility to ensure residents receive proper treatment and care for special services, including management of care for intravenous infusions and assessment of the venous access site and amount of fluid administered.** **1.)** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** **No other residents were affected.** **There were no other residents receiving IV therapy in the facility at the time of survey.**	05/27/2011

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	arm was lying across the right arm, with the palm of the right hand visible and slightly puffy. During interview on 5/20/11 at 11:35 a.m., LPN #4 indicated the resident had IV fluids which the family had decided to discontinue due to infiltration. LPN #4 indicated she recalled the resident had two IV access sites - one in the left hand and one in the right antecubital space. LPN #4 indicated both sites had infiltrated. During interview on 5/20/11 at 12:00 p.m., Resident M's two daughters indicated the family did not wish for the resident to have IV fluids again, since the IV sites had infiltrated and the resident's arms had become puffy. During interview on 5/20/11 at 12:50 p.m., the Director of Nursing (DON) indicated the Nurse Practitioner started the first IV in the resident's left hand, and she, the DON, had started the IV in the right		**Nurses Notes for this resident indicate on 5-20-11 that there were no signs of infiltration. This resident has not had any other IV therapy since that time.** **An in-service was held on 5-20-11 for RNs and LPNs on the facility policy and procedure regarding IV therapy and assessments that should occur when IV therapy is being administered, IV documentation and the form to be used for documentation of IV therapy.** ***2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.*** **No other residents were affected.** **There are no residents receiving IV therapy in the facility at this time.** **In the future, if the DON should find that intravenous**	

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	arm when the first IV infiltrated. The clinical record for Resident M was reviewed on 5/20/11 at 11:50 a.m. Nurse's Notes for 5/14/11 at 7:30 p.m. indicated, "[Name of Nurse Practitioner] came to facility to check res. [resident]. N.O. [new order] morphine sulfate 0.5 - 1.0 mg IV 1 - 2 [symbol for hours] PRN [as needed]. IV site to L [left] FA [forearm]. Flushes with ease, blood return." Nurse's Notes on 5/15/11 at 12:00 a.m., indicated morphine sulfate was administered as ordered, and the IV site was assessed with "... [symbol for no] S/S [signs and symptoms] of infiltration or infection noted...." Nurse's Notes indicated the IV site was assessed again on 5/15/11 at 12:30 p.m. with "...Site clean and dry [symbol for no] S/S infection or infiltration...."		**therapy is not being administered, assessed, or documented as per facility policy, she will intervene immediately to make sure that the resident is being cared for and that appropriate documentation is in place to support the administration of the IV therapy. Once that is done, she will re-train any RN or LPN who has been involved in the identified noncompliance regarding the facility policy and procedures for IV therapy. Progressive disciplinary action will be followed for continued noncompliance.** ***3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** **The IV documentation form includes places to document every 8 hour site monitoring for signs and symptoms of**	

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	Nurse's Notes indicated the IV site was assessed again on 5/16/11 at 12:53 p.m. as "...[symbol for no] S/S infection or infiltration to IV site." Nurse's Notes for 5/16/11 at 10:00 p.m., indicated, "[Name of attending physician] here to visit & N.O. noted...D5 1/2 [5% dextrose solution with 1/2 strength normal saline] [symbol for with] 20 mEq [milliequivalents] of KCl [potassium chloride] at 100 cc hr [hourly] cont [continuous]...." Nurse's Notes for 5/16/11 at 2:00 a.m., indicated, "IV fluids started and infusing at 100 cc/hr via LFA #22 [gauge of IV cannula]...." Nurse's Notes for 5/17/11 at 7:40 a.m. indicated the IV fluids continued to infuse at 100 cc per hour. The next Nurse's Note related to the IV site was 5/17/11 at 12:00 p.m.		**complications, IV fluid order, the rate of infusion, and the amount of fluids infused each shift. The nurses have been instructed that they are to document in the nurses' progress notes any unusual observations or complications that they observe or assess whenever IV therapy is being administered.** **The "Medication Pass Intake" form was revised to reflect the amount of fluids received via IV each shift. This amount will be transcribed from the MAR each day onto the residents individual Intake Log.** **The Director of Nursing or designee will audit the 24-hr. report and the focus charting at least 5 days per week. If she finds that a resident has new IV orders, she will ensure the IV orders include IV fluid order, the rate of infusion, and the amount of fluids infused per shift and monitoring for signs and symptoms of complications.**	

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	and indicated, "Res. IV site infiltrated. Noticeable pooling to L FA & hand...." Physician's orders were received to discontinue and relocate the IV. Documentation failed to indicate further assessment of the IV site where the IV cannula was removed or the area affected by the infiltration to the left arm. Nurse's Notes for 5/17/11 at 2:00 p.m., indicated, "IV inserted into R [right] AC [antecubital] X 2 attempts 22 g. IVF [intravenous fluids] cont. as ordered...." The next Nurse's Note related to the IV site was 5/18/11 at 3:45 a.m. and indicated, "N.O. D/C [discontinue] IV R AC r/t [related to] infiltration. Hold IVF until morning...." Documentation in Nurse's Notes failed to indicate the IV site was assessed from time of insertion into the right arm until more than 12 hours later.		**She will review the documentation on the forms and care plan to make sure that it is complete and that the appropriate assessments & the results of those assessments have been noted as required. If any issues are identified during the reviews, the Director of Nursing will follow through as indicated in question #2.** ***4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** **The Director of Nursing or designee will bring the results of the audits (QA audit tool # 272-1) to the monthly QA & A Committee meeting.** **The committee will review the results and provide recommendations for any process identified as needing improvement. This will be followed up by the Director**	

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	Documentation in the Nurse's Notes failed to indicate an amount of IV fluids administered to the resident. The Treatment Record for May 2011 indicated, "D5 1/2 NS [symbol for with] 20 mEq of KCL cont" with an initial for a nurse's signature on the 10:00 p.m. to 6:00 a.m. shift for 5/16 to 5/17/11. No other documentation was indicated on the Treatment Record related to the continuous infusion. Documentation failed to indicate the amount of IV fluids infused. The Resident Fluid and Meal Percentage Intake Log failed to indicate the amount of fluid received intravenously. The resident's care plan, dated 5/14/11, indicated, "Problem: IV site to (L) [left] hand" with undated notation of "Infiltrated - move to L [sic] antecubital." Interventions included, but were not limited to, "Monitor IV site for changes: i.e.		**of Nursing or designee, who will report on the status of these recommendations at the next QA & A Committee meeting.** **While the process of the review of the 24-hr. report and the focus charting by the Director of Nursing or designee, will continue on an ongoing basis, the documented audits will continue through the next 90 days. At that time, the QA & A Committee may terminate the documented audits if the facility has reached 100% compliance.** **Date of Compliance 5-27-11.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	05/20/2011

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	redness, drainage, pain, swelling....Monitor intake and output....Document IV administration on flow sheet/MAR [Medication Administration Record]." During interview on 5/20/11 at 1:40 p.m., LPN #6 indicated Resident M's first IV that infiltrated was in the left forearm, and she pointed to area just above the wrist. LPN #6 indicated when the IV infiltrated on the left, the resident had a pooled pocket of fluid under the forearm, and the left hand was swollen. She indicated the area was not cool or warm to the touch. LPN #6 indicated when the IV on the right arm infiltrated, the swelling was mostly in the right hand, and the right arm was slightly swollen. She indicated when she noticed the problem, the tourniquet used to start the IV was lying unfastened under the resident's arm up under the sleeve of her gown. The facility's "IV Policy and			

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	Procedures" was provided by the MDS (Minimum Data Set) Coordinator on 5/20/11 at 1:30 p.m. Review of the procedure for "Monitoring an IV Site" indicated, "IV sites will be monitored at least once every 8 hrs [hours] by the IV trained nurse....Step 1. Observe the IV site for signs of complications described in the following: Edema - Swelling is an indication of infiltration; Blanching - Blanching is an indication of infiltration; Redness - Redness in the area of the tip of the catheter and along the vessel may be an indication of phlebitis and/or infiltration; Moisture or exudates at insertion site: This may indicate...Infiltration...Infection of the area." Review of the procedure for "Continuous IV Administration of Fluids/Medications" indicated, "Monitor ...the site throughout the infusion...." During interview at this time, the MDS Coordinator indicated the facility did not use a separate IV Flow Sheet to record administration of fluids but the			

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	information would be on the MAR and Intake and Output Record. She indicated the information was not indicated on the resident's records. This federal tag relates to Complaint IN00090827. 3.1-47(a)(2)			